Community Off-Site Vaccine Administration Record (VAR)—Informed Consent for Vaccination

Walgreens

Please complete Sections A, B, C for all immunizations prior to the clinic date. Medical/Pharmacy Insurance (Section D), located on back of this form, must be completed if the "Off-site Clinic Billing Group" (box to the right) is blank, or as directed by your employer	OFF-SITE CLINIC BILLING GROUP	Store number: Store address: Rx number:

SECTION A Please print clearly.

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Email address:** _____

Walgreens will send vaccination information from this visit to your doctor/primary care provider using the contact information provided below.

Doctor/primary care provider name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

I want to receive the following vaccination(s): _____

SECTION B The following questions will help us determine your eligibility to be vaccinated today.

All vaccines			
1. Do you feel sick today?	☐ Yes	☐ No	☐ Don't know
2. Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list. _____	☐ Yes	☐ No	☐ Don't know
3. Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
4. Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes	☐ No	☐ Don't know
5. Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	☐ Yes	☐ No	☐ Don't know
6. For women: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
For chickenpox, MMR® II, shingles, yellow fever only: Only answer these questions if you are receiving any vaccinations listed above.			
7. Have you received any vaccinations or skin tests in the past four to eight weeks? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
8. Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ Yes	☐ No	☐ Don't know
9. Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes	☐ No	☐ Don't know
10. Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐ Yes	☐ No	☐ Don't know
11. Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes	☐ No	☐ Don't know
12. Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	☐ Yes	☐ No	☐ Don't know
13. Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR® II only)	☐ Yes	☐ No	☐ Don't know

SECTION C

I certify that I am (a) the patient and at least 18 years of age, (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to Walgreens or Duane Reade and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and/or had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each applicable Provider, its staff, agents, successors, divisions, affiliates, subsidiaries officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent by using a state-approved opt-out form or, as permitted by my state law an opt-out form ("Opt-Out Form") furnished by the applicable Provider (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry, or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to the applicable Provider and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my vaccination information to or through the State HIE as required or permitted by law. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis), proof of vaccination to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize the applicable Provider to (a) release my medical or other information including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services, as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Patient signature: _____ **Date:** _____
(Parent or guardian if minor)